# Soundview Medical Associates, LLC

## *Patient Authorization for Use and Disclosure of Protected Health Information*

Patient Name_____ Phone Number _____

Date of Birth_____ Medical Records # _____

Address:_____

- I hereby authorize Soundview Medical Associates, LLC to disclose the following health information to:_____
- I hereby authorize: _____(non-Soundview practice/provider) to disclose the following health information to Soundview Medical Associates.
  - I am making this request because I am leaving Soundview Medical as a patient (please check one): Yes _____ No _____
    Reason: _____

<u>Specific information to be released:</u>

1. Information to be disclosed:
   - Medical records from this date_____to this date_____.
   - Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology reports, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

   Comments:
   _____
   _____

2. To the extent applicable, I understand that my medical records may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do **NOT** permit information of this type, if it exists, to be released. I understand that if I do not check off the circle, Soundview Medical Associates, LLC will release such information about me if it exists.

   - HIV/Aids infection
   - Genetic Information
   - Mental Health
   - Sexually transmitted diseases
   - Treatment for Alcohol and/or Drug Abuse

3. I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

4. It is my understanding that this authorization will expire in one (1) year to the date signed below. I understand that I may revoke this authorization by notifying Soundview Medical Associates, LLC. I understand that any previous disclosed information would not be subject to my revocation request.

5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits, unless otherwise described in the space provide here:

_____

Please choose which method you prefer:

☐ $0.65 per page payable before records are sent or picked up. If there is an outstanding balance on account, I understand that I am responsible for payment before records are released to me.

☐ Encrypted USB drive: Flat fee of $30.00

**This form must be fully complete before signing.**

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____

Print Patient's Name

_____ _____

Print Name of Legal Representative (if applicable) Relationship to Patient

____ Will pick up the records at the office

____ Would like the records mailed